Physician Group Overview

Overview: Physician groups come in all shapes and sizes; the purpose of this document is to give the reader a broad-based understanding on the various types of groups.

History:

In terms of relationships, there are hospitals, physician networks, and independent individual doctors such as family physicians and specialists. Physicians agreed to take calls without pay and to voluntarily serve on committees dealing with quality of care and privileges. In recognition of this volunteer work, doctors held a great deal of power over hospital operations. The medical staff organization (MSO) and its medical executive committee held sway over hospital administrators, and CEOs who fought with the MSO were likely to lose their jobs.

In the 1970s-1990s, HMOs grew to prominence. With this, the traditional relationship between hospitals and daily physicians changed. The funding for hospitals dried up, and they had to find different revenue streams to fund their research. To generate much needed funds, hospitals turned to patients.

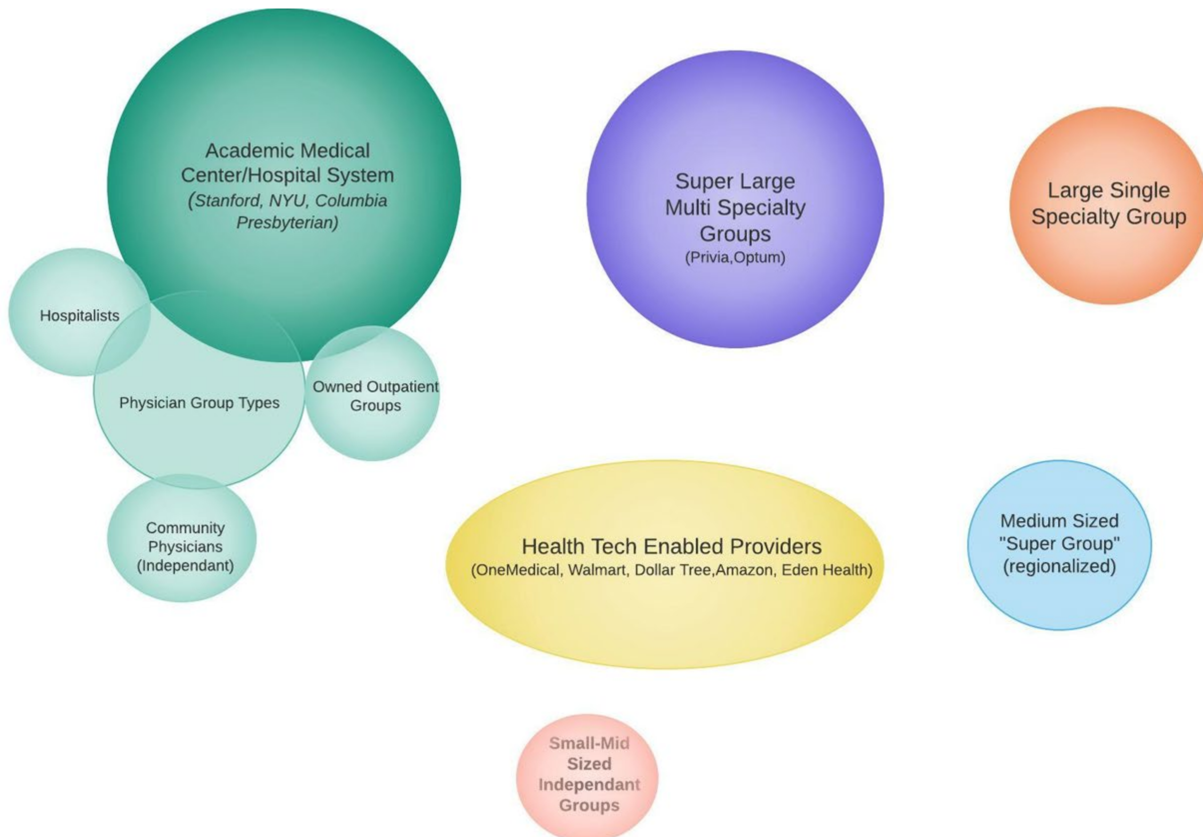
In a fee-for-service model, more encounters generate more cash. Hospitals need a lot of patients and a lot of surgeries. When healthcare became more structured and the vast majority of patients had insurance or Medicare, these surgeries became the new norm. Hospitals used physicians and physicians' groups to feed patients to them, thus ensuring a large client base.

To best accomplish this, hospitals stretched out their financial umbrellas to cover physicians' groups. Individual doctors would become employees of the hospital, and the entire system cared for patients from annual checkups to emergency bypass surgery. In more modern times, when a patient seeing Doctor Jones at XYZ Family Medicine needed an appendectomy, they were conveniently sent to XYZ Hospital. For the patient, this ensures a seamless transfer of data as the hospital and the family practice share electronic medical records. For the hospital, this ensures a continuing stream of patients and thus revenue from procedures. For the doctors who work in affiliated medical groups, however, the benefits are less enticing.

The doctors became the workhorses of the hospital, responsible for turning the wheel that kept the entire operation afloat. They felt undervalued and overworked and eventually quit to go into private practice. Private practice comes with its own challenges such as staffing, billing and following changing regulations. Some doctors are like entrepreneurs, eager to work for themselves. Others would prefer to be employees and focus on medicine rather than administration. Predominantly, the newest generation of physicians, fresh from medical school, are accepting employment in hospitals. With new legislation changes, and consolidation, the cycle of disillusion will start all over again.

Types of Physician Groups:

The illustration below provides the basic understanding of the various types of physician groups. Whether in a formal or informal manner, each of the bubbles interacts with each other in different ways.



- **Academic Medical Centers** – The biggest of these players they consist of the large hospital/health system groups throughout the country. Each of these organizations has the a Physicians group attached to the hospital with the following type of providers:
  - *Hospitalists* – Physicians who take care of all the patients who are admitted to the hospital. Each department usually has a couple of hospitalists who are handling the day-to-day inpatient work.
  - *Employed Outpatient Groups* – Physician groups who were previously independent and are now owned by the hospital as an ambulatory outpatient group.
  - *Community Physicians* – Traditionally independent physicians who are covered by the hospitals contract as part of an Independent Physicians Association (IPA) and are not employed by the hospital.
- **Super Large Multi-Specialty Groups** – Multi-state organizations who are not specifically connected with one hospital. Usually has PE or VC money in and is looking to become as big as possible. Acting in a pseudo franchise model, these groups usually have a local or regional organization that is owned by a larger organization.

- **Large Single Specialty Groups** – Structured similarly to the "Super Large Multi-Specialty Group" the singe specialty groups have local/regional organizational leadership focused on one specialty. These roll ups are focused on high profit margin specialties that can be either independent of the hospital (ophthalmology, dermatology, plastic surgery) or embedded within the hospital (anesthesia, emergency department). While primary care could fall within this category, the reliance on other specialties for procedure income almost guarantees a partnership with non-primary care providers.
- **Mid-Sized "Super Groups" (single or multi-specialty)** – These are single state/tax ID groups that grow within their area. In many cases they are either ready to become much bigger or are happy with their independence.
- **Small-Mid Sized Groups –** The smallest of all the players. The independent small groups may have 1-3 offices. These types of groups have come back a little as being a back-up to a moon lighting career. They have been around for a very long time and are either generational (family) or are meeting an underserved area. These types of groups are the easiest to sell into when trying to launch a product.
- **Health Tech Enabled Providers** – The newest batch of organization trying to deliver on providing care with the best possible customer experience. Each of these organizations approach the healthcare delivery landscape from their own perspective. Walmart Health is providing care in areas where it is not available to its employees and customers in an inexpensive way. Eden Health is tackling the delivery problem not through traditional insurance payors, rather by going right to the employers who are paying the bill. One Medical is curating a relationship for a more metropolitan group of patients. All of these offerings are re-imagining healthcare and healthcare delivery in a customer focused way.

Decision Making Process:

- **Academic Medical Centers** – This is the most complicate of structures with various points of entry including:
  - *C-Suite – CEO, CFO, CMO*
  - *Board Member or Trustee*
  - *Department Chairs or Important Physicians*
  - *Innovation Team* – Possibly run independent of the normal hospital operations teams. These groups are much more capable of viewing and acting on the idea of startups as an investment.
  - *Technology Team – CTO, CIO, CISO*
  - *Quality Team*

  Each of these teams have a hierarchy of people or teams that will review purchasing decisions. These will include but are not limited to the following:

  - *Legal*
  - *Finance*
  - *Technology*
  - *Security*
  - *Administrative Executive Sponsor*
  - *Quality*

  Tips:

  - *Do your research, understand the hospital's needs and decision approval process.*
  - *Include as many cross-functional teams as possible*
  - *The innovation teams are usually the easiest sales path in many organizations*
  - *Physician leaders hold much more power than they realize*
  - *If it is not budgeted for, you may have to wait until the next budget cycle.*

  From a friend who worked in a senior role a Montefiore:
  There was a process to get the project approved by a Senior VP and EVP (depending on amount) and then it would go to IT, budget and legal for approvals. If one of the 3 EVPs wanted it to happen then it happened. Certain Senior VPs could make it happen as well. All depends on who is supporting the initiative.

  "Case Study to make it clear what the path will look like"

- **Super Large Multi-Specialty Groups** – Much like hospitals, these are huge organizations with complex political structures. Unlike hospitals, the decision-making process is normally made within a central administrative structure. The hardest part is uncovering who the

players are within that structure. Much like Payors, these groups may have national, regional, state, and local management.

Tips:

- Always try to work at the national level. The sub levels can make some limited decision making, you want to be able to see the biggest picture.
- If it is not budgeted for, you may have to wait until the next budget cycle.
- Usually, the best entrée is through the PE or VC company that is backing the organization.
- The CMO is vital in the clinical purchasing decision-making process.

Purchasing decisions may include one or more of the following committees or departments:

- *National Corporate*
- *PE/VC Sponsor*
- *Legal*
- *Finance*
- *Billing/Coding*
- *Technology*
- *Quality*

- **Large Single Specialty Groups** – Individual physicians will have much less sway in these organizations. Focus on the corporate organization running the group.

Tips:

- Identify the physician leaders
- Include IT in the initial conversations
- Ensure that the organizational leaders are on board and included in meetings.
- Don't push on something that isn't an immediate need.
- Sell the CEO/COO and highest Physician leader. They are the people who will be able to be your advocates.

Purchasing decisions may include one or more of the following committees or departments:

- *PE/VC Sponsor*
- *Legal*
- *Finance*
- *Billing/Coding*
- *Technology*
- *Administrative Executive Sponsor*
- *Quality*

- **Mid-Sized "Super Groups" (single or multi-specialty)** – Decision making ability usually lands on the desk of the top administrator in these groups. If there is organizational framework, there will be politics around any purchasing decision. Focus on the organizational needs and how the product can resolve those needs with concrete data.

Purchasing decisions may include one or more of the following committees or departments:

  - *Board of Managers*
  - *Legal*
  - *Finance*
  - *Billing/Coding*
  - *Technology*
  - *Quality*

- **Small-Mid Sized Groups –** This is the easiest group to sell from a decision-making perspective. The ultimate decision maker will in most cases the person you are pitching to without any hierarchy. The challenge is that these entrepreneurs are extremely cost conscience which can lead to slow or delay sales results.

Challenges – Present and Future

- **General** – This will serve as a catch all for the challenges faced by each type of organization:

  - Staffing
    - Availability of support staff
    - Physician shortages
      - Primary Care
      - Mental Health – The need is higher than ever, and the skilled clinicians are just not available.
    - Burnout in all sectors of the staff
    - Competition leading to higher cost to hire new employees
    - Employee Engagement and Retention
  - Change in regulations
    - Price Transparency
    - Restrictive Covenants
    - No Surprise Bill Act
  - Shifts in Technology
    - Integration of new service delivery platforms into traditional framework – The increased utilization of telemedicine has led to concerns around the long-term viability of these service offerings. Specifically:
      - Reimbursement
      - Patient Retention
      - Physician and Patient willingness to use new technology
    - Cybersecurity – Hardening the infrastructure is becoming increasingly difficult to achieve.
  - Data Management and Patient Experience - There's no single "source of truth" that providers can use to optimize the patient experience. For instance, when patients switch insurance plans or healthcare providers, most medical practices rely on patients' self-reporting to reconstruct their records. As a result, not all the information is transferred properly and it's very challenging to harness the power of data and generate accurate insights. In addition, healthcare data comes from many sources in a variety of formats. Currently, there's no single system or technology.
  - Rebuilding Patient Trust – This is an area that has grown out of COVID and could be part of the hangover for a while.

- **Academic Medical Centers**

  - Competition – There are two factors that lead to increased competition for these organizations.

        - Internal - Push and Pull of Quality Medicine and filling In-Patient beds. This is the existential dilemma faced by many hospitals. How can I keep my bed filled while still generating the best result on my risked based contracts? New service delivery options are starting to sprout up (ET3), in the end, many hospitals trying to find billing loopholes.
            - Example: A patient has been discharged less than 24 hours ago with COPD. They have bounced back to the ED with an exacerbation. Instead of admitting them to the hospital and taking the quality hit, the put them in observation until the patient is stable and send them home. This is not categorized as an ED visit or an admission, plus they can stay in observation for almost 24 hours.
        - External – Competing with other hospitals to get and retain the greatest number of patients lives as possible. In NYC where there are multiple academic medical centers, as well as, varied levels of service providers, the competition is most fierce.
    - Shifts in Technology
        - Technology Debt – Many hospitals are still struggling with technical debt, the cost of additional rework caused by implementing an easy, but limited solution instead of implementing a better approach that would take longer.
    - Health Equity – Prioritizing health equity in minority communities is becoming much more relevant to large organizations. This is much more unique to hospitals and large healthcare organizations than physician groups due to their place and status in the community. Consequently, the smallest organizations are benefiting from grants and resources from the largest organizations to better serve these populations.
    - Data Management – These organizations (along with the Super Large organizations) have the hardest problems managing data. Divisions and departments can sometimes be on totally different systems. Outsourced Emergency Departments, Anesthesia Departments, and Ambulatory Surgery Centers increase the level of complexity.

- **Super Large Multi-Specialty Groups**

    - Changing payment models – The more complexity the bigger the challenge. Organizations like these have a hard time shifting to new payment models because that requires shifting the workflow required by many levels of the organization. Additionally, the technology changes are complex and hard to implement in these organizations.
    - Competition – These groups are built on a grow or die model. As the competition grows the number of available lives diminishes.
    - Technology
        - Keeping current is very expensive and time consuming
        - Cybersecurity - The bigger you are the bigger the target
    - Data Management – As mentioned above, combining data from various systems is difficult at best. The challenge here is integration of this data across organizations that may have previously been competitors.

- Organizational Culture – This is a common theme amongst Physician Services companies. Retaining a organizational culture during growth is massively difficult.
- Investor Pressure

- **Large Single Specialty Groups** –
    - Competition – Single specialty groups must manage competition in a much different way. There may not be as many clinicians in their specific specialty or in their geographic region. Yet, if the local groups do not have faith in their ability, referrals could dry up. Alternatively, if the local hospital wants to build a competitive offering to increase their in-patient census, they could pour in money even causing losses to ensure patient volume.
    - Changing payment models – As a single-specialty group, value-based payment models do not have normally translate. The challenge is that procedural reimbursement are not necessarily going up. As more specialty care is being wrapped into preventive care, the reimbursement goes down. Therefore, the unit economics change the whole practice financial model.
        - Example: The reimbursement an OB/GYN receives for a pregnancy has gone down for around $15,000 20 years ago to close to $3,600 today.
    - Technology
        - Keeping current is very expensive and time consuming
        - Cybersecurity - The bigger you are the bigger the target
    - Organizational Culture – This is a common theme amongst Physician Services companies. Retaining organizational culture during growth is massively difficult.
    - Investor Pressure
    - Regulatory
        - Management of various state rules
        - Retaining auditing diligence
        - Reviewing and keeping up with coding requirements

- **Mid-Sized "Super Groups" (single or multi-specialty)** –
    - Competition – Being squeezed in the middle, having a differentiator is key to how to get the name out. As the financial burden increases the ability to leverage marketing resources diminishes.
    - Regulations
        - Understanding E/M Code Changes
        - Becoming a Target – At this level you are starting to become "on the radar" of auditing companies. Ensuring compliance is not just about coding/documentation standards, now OSHA, CLIA, HR, Privacy have increased scrutiny because you are a target.
    - Administrative Burdens – Adoption has not caught up to the advances in automation. Barriers are multi-factored in this group, reliance on staff or currently used technology, time to implement, cost, and complexity of implementation are some of the examples.

- Managing to the Whole and not the Individual – This is a common problem amongst organizations when they are growing into the next rung on the ladder. These group tend to be in between a fully standard operation and an individualized operation.
- Ongoing Supply Chain Issues

- **Small-Mid Sized Groups –**

  - Competition – Being at the bottom requires an ability to create a niche where the patients you need are able to find you. Everyone is going to be out for your patients, how do you retain them and find more in a cost-effective manner.
  - Getting Paid and Seeing enough Patients - In countless surveys and studies, and across specialties, physicians consistently cite the time and energy they must devote to filling out forms and other administrative tasks near or at the top of their list of grievances. The mantra repeatedly heard throughout the profession is, "This isn't why I went into medicine."
    - Paperwork and administrative requirements are also linked to the alarming increase in physician burnout rates, especially among primary care doctors. When Medical Economics asked doctors what contributed to their feelings of burnout, 31% cited "paperwork"—more than twice the percentage of the second-leading cause, a poor work-life balance.
  - Regulations
    - Understanding E/M Code Changes
  - Ongoing Supply Chain Issues

- **Health Tech Enabled Providers** –

  - Fulfilling the promises made to investors and shareholders – This is the catch-all for all these providers.
    - Does the technology work?
    - Is the financial model viable?
    - Will patient come?
    - Will we hit growth expectations?
  - The challenges are becoming less about patient care and more about the corporate financial growth targets.